# STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

## DEPARTMENTOF HEALTH

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS, DEPARTMENT OF HEALTH, BOARD OF MEDICAL LICENSURE AND DISCIPLINE

NO. C91-045

In the matter of: WU-HSIUNG SU, M.D.

#### ORDER

Pursuant to a Specification of Charges of Unprofessional Conduct dated August 12, 1993, issued on behalf of the Board of Medical Licensure and Discipline by the Investigating Committee of said Board, Defendant Wu-Hsiung Su, M.D. (hereinafter referred to as "Su") was summoned to appear before the designated Hearing Committee of the Board to answer seven charges arising out of Su's care and treatment of Patient A as follows:

1) Su was charged with unprofessional conduct in the practice of medicine in violation of Section 5-37-5.1 of the General Laws of Rhode Island 1956, as amended (1987 Re-enactment) by reason of actions and conduct set forth below, to wit:

That a forty-four (44) year old woman (the patient) was under Su's care and treatment from January 1989 through November 13, 1989. Su had publicly advertised a weight loss program. This patient responded to the public advertisement, and was treated for weight loss by Su from January, 1989 through November 13, 1989.

That within that period, Su treated the patient with Melfiat, an appetite suppressant, from January 7, 1989 through October 30, 1989, with the exception of a two (2) week period, when the patient was being treated for Coryza. Su also treated the patient with Hydrochlorothiazide (HCTZ), a diuretic, from early in 1989 through April 18, 1989. From approximately April 1, 1989 through the end of her treatment, Dr. Su regularly injected the patient with Vitamin B-12.

That in February, 1989, the patient complained that she was suffering from itchiness, a burning sensation and scabbed sores of the scalp. Dr. Su prescribed a hydrocortisone cream and continued the patient on the appetite suppressant and the diuretic.

That Su ordered laboratory tests, including a blood glucose level, but the test results were not revealed to the patient, and the patient was continued in the weight loss program.

That during the course of her treatment, the patient complained that she was thirsty and had frequent urination, but her complaints were not reflected in Su's treatment notes or records.

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That on November 18, 1989, the patient was admitted to a hospital by her family physician through the emergency room because of a history of excessive thirst, excessive urination, a sixteen (16) pound weight loss in two (2) months, difficulty in focusing her eyes and reported high blood sugar. The patient's blood sugar level was determined to be 588. The patient was diagnosed as having Diabetes Mellitus.

- 2) Su was charged with unprofessional conduct in violation of Section 5-37.5.1 (2) in that he failed to provide a well designed and strictly supervised weight loss program such as appeared in his advertisement and that said advertisement was misleading and had a tendency to deceive the public.
- 3) Su was charged with unprofessional conduct in violation of Section 5-37-5.1 (19) for failing to provide a well designed and strictly supervised weight loss program, in that there was no indication of the recommendation of an exercise program or specific diet with appropriate diet counseling.
- 4) Su was charged with unprofessional conduct in violation of Section 5-37-5.1 (19) in that he did not provide a well-designed and strictly supervised weight loss program in that his continued use of Melfiat 105 was medically unjustified, was for an excessive period of time, and was then stopped abruptly.
- 5) Su was charged with unprofessional conduct in violation of Section 5-37-5.1 (19) in that he did not provide a well designed and strictly supervised weight program in that the use of hydrochlorothiazide and injectable Vitamin B-12 with respect to this particular patient was not justified on the basis of any scientific evidence of the efficacy of such treatment in weight loss programs.
- 6) Su was further charged with unprofessional conduct in violation of Section 5-37-5.1 (19) in that he failed to provide a well-designed and strictly supervised weight loss program, in that the use of hydrochlorothiazide and injectable B-12 were without medically scientific basis, were medically unnecessary and were medically unjustified.
- 7) Su was charged with unprofessional conduct in violation of Section 5-37-5.1 (19) in that a.) he failed to note certain important symptoms and complaints of the patient i.e. excessive thirst and frequent urination, in the patient's medical record, failed to advise the patient of the relevant diagnosis related to these complaints, and failed to institute the indicated therapy related to said complaints; b.) he prescribed diuretics and appetite suppressants for 10 months and gave vitamin B-12 injections at bi-weekly to monthly intervals without any specific indication of the need for such medications; and c.) he failed to diagnose Diabetes Mellitus, failed to appraise the patient of the

diagnosis, and failed to institute indicated therapy.

This matter was set down for hearing commencing on November 3, 1993.

The three members of the hearing committee were as follows:

Barry Jasilli, Esq., Chairman Mary B. Arnold, M.D. Sally Jane Thibodeau, Ph.D.

Maureen A. Hobson, Esq. served as legal counsel to the hearing committee.

On behalf of the State:
Joseph G. Miller, Esq.

On behalf of Wu-Hsiung Su, M.D.: J. Renn Olenn, Esq.

There were a number of exhibits introduced by counsel for each of the parties, and those were duly marked, entered in the record of the proceedings and reviewed by the Committee in reaching a decision. Dr. Su did not appear on his own behalf.

The State's first witness was Patient A. She is a 50 year old woman who began treatment with Su in January 1989. She consulted him pursuant to an advertisement she saw which indicated that Su's practice included a medically supervised weight loss program. Her husband was also a patient of Su at the time. She testified that on her initial visit she was asked to fill out a patient questionnaire, but had only gotten through the first page when Su came out to the reception area to get her. He took the questionnaire from her. Su asked her if she had high blood pressure, to which she responded no. He weighed her and asked her if she was taking any thyroid medication. She told him she was taking Todine and Synthyrold at the rate of one per day. At the time, she was 5 foot 3 1/2 inches tall and weighed 154 pounds. Sum also asked her if she ever experienced migraine headaches, to which she responded no. In response to his inquiry, Patient A told Summer that she exercised regularly. In fact on examination, Patient A testified that the only exercise she engaged in was taking a short walk at work during her lunch break. Although the questionnaire listed a host of ailments and possible medical conditions which Su had crossed out, he never asked Patient A about any of them. Su did give her a check up, including an EKG. He never asked her anything about her eating habits or calorie consumption. Patient A was in Su's office for about 15 minutes. At the end of the session, he prescribed a diuretic and an appetite suppressant which he said would last her for a two (2) week period until her next appointment. Su did not provide any weight loss counseling to Patient A, nor did they discuss a target weight loss.

At Patient A's next session with Su, he listened to her chest and lungs and tested her reflexes. There was no discussion of her diet, calorie intake or exercise program for the previous two (2) weeks or for the upcoming period. She saw Su for approximately ten (10) minutes and he gave her more prescriptions. Each visit with the doctor was billed to the patient's medical insurance carrier at \$30.00 per visit.

On Patient A's next visit, February 4, 1989, she told Su of a problem with sores on her scalp. He asked her about whether she had pets and gave her a prescription for a shampoo. He told her it looked like she might have a tick bite. On February 18, 1989, the sores were worse. Su's notes (exhibits 3A and 3B) indicate he prescribed a cortisone cream. However, Patient A said he did not prescribe any cream and although she was still complaining about the sores, he did not look at her scalp on that date. Once again, Su did not discuss diet, food, drink, calories or exercise. He did usually take her blood pressure and in February 1989 Patient A complained of excessive thirst and increased urination. Su told her it was the effects of the diuretic. He continued her on the prescriptions, and on April 1, 1989 she began getting B-12 vitamin The sores on her scalp were continuing, but Patient A testified that she stopped bringing it up with Su because she was embarrassed. She believed his theory that the sores were the result of tick bites from the dogs. Patient A then testified that sometime in the "warm weather" of 1989, Su discontinued the diuretic, but kept her on the appetite suppressant. All this time, she persisted in her complaints of excessive thirst and increased urination at each visit. At no point during any of these visits was diet, exercise or weight loss discussed with Patient A.

In August of 1989, Su took another blood test, but Patient A did not get the results. Her treatment regimen remained the same throughout the summer of 1989. She was seeing Su bi-weekly.

In October, Patient A began to complain of tiredness, in addition to the thirst and urination. Su conducted another blood test at that time. Su told Patient A that the results of the blood test were normal, a little on the low side. He explained to her that he took the blood test to rule out sugar.

After the third blood test the patient became concerned. She testified that her thirst was insatiable and she was constantly urinating. Patient A contacted her family physician, Dr. Ramirez. She went to Landmark Medical Center on November 18, 1989 pursuant to Dr. Ramirez's instructions for further tests. She was hospitalized that same day and diagnosed with Diabetes Mellitus. Subsequent to her hospital stay, Patient A discontinued treatment with Su.

The State's next witness was Patient A's husband. He testified that he had been having regular bi-weekly treatments with

Su since 1987. In the Fall of 1988, his wife saw Su's advertisement for a weight loss program. The husband told his wife Su was "nice" and she should go to him. The husband accompanied Patient A on every visit she had with Su. He testified that Su's office was such that he could hear all of his wife's conversations with Su. There was never any discussion of weight loss, diet or exercise. No dietician was ever present. Other than prescriptions, Su provided nothing else to Patient A. The husband testified that almost every time his wife had an appointment with Su, she had to use his bathroom. Su said it was due to the diuretic. "He was present at his wife's appointment on October 30, 1989. Patient A, on that date, told Su, again, that she was losing weight, but that she was tired all of the time, thirsty and had to urinate frequently. Su said those were symptoms of "sugar" and he would have to check it out. After that visit, Patient A consulted her family physician which resulted in Patient A's hospitalization and diabetes diagnosis. Patient A's husband continued treatment with Su after his wife's hospitalization.

Su asked him why his wife had not returned. When informed by the husband of her diabetes, Su told the husband that the diagnosis was "odd" since "her blood sugar was high."

The State's third witness was Charles B. Kahn, M.D. Dr. Kahn is a Board Certified internist and endocrinologist. He testified that there is no such specialty, per se, as "weight loss medicine", although many doctors, including himself, practice it. Dr. Kahn testified that he was familiar with the community standards for weight loss intervention. He indicated that a properly supervised weight control program should involve 1.) examination, history and evaluation of the patient, and, 2) a nutritionally balanced written diet which includes a reduction in caloric intake. The diet should be prepared by the doctor or an affiliated dietician. The diet should be monitored by the doctor for compliance by the patient, and there should be doctor-patient discussions of the effectiveness of the diet. Dr. Kahn testified that all of the literature on the subject of weight loss suggests that diet is the cornerstone to an effective weight loss program. In addition to reducing calorie intake, a good diet program also maximizes calorie expenditure Therefore, exercise is very important. To the extent the patient is able to participate, exercises should be employed. The doctor testified that pharmacological intervention should be the last thing considered in a weight loss program, and only as an adjunct to diet and exercise, to the extent those are unsuccessful. Medication is not normally used by doctors to reduce a patient's weight because it does not promote initiating a life style change, which is the thrust of a good weight loss program.

Dr. Kahn examined Su's records for Patient A. He could find no evidence therein to indicate that the patient had been given a diet or an exercise regimen. In his opinion, to a reasonable degree of medical certainty, Su's failure to provide the patient

with a diet and/or exercise regimen constituted a departure from recognized standards of medical practice in the area.

Dr. Kahn also addressed the specific drugs prescribed by Su. He stated that if used at all, the appetite suppressant and diuretic should have been used for a very short time, a few weeks. Su's records indicate he used drug intervention with Patient A for nine (9) to ten (10) months. There was nothing in the patient's record to warrant prolonged drug use. Dr. Kahn also testified that Su's complete failure to document complaints of the patient relative to thirst and frequent urination constituted a departure from recognized standards of medical practice. On crossexamination, Dr. Kahn admitted that there was no standard of practice which specifically required a written diet. However, with the literature he had read and the seminars he has attended, it is recommended that where diet is an issue, it should be put into written form and routinely discussed with the patient.

The defense introduced into the record the deposition testimony of George L. Blackburn, M.D. Dr. Blackburn has an M.D. and a Ph.d. in Nutrition and Bio-Chemistry. He operates an obesity laboratory and works out of Harvard University. He reviewed Su's treatment of Patient A and felt the same fell within the reasonable standards of medical care. He characterized Su's treatment of the Patient as "step down care". Dr. Blackburn stated that where the physician is providing all of the care, he need not document everything he is doing because he's doing it himself. There is no requirement for a written diet. Dr. Blackburn indicated that the doctor and patient should have engoing discussions of diet and exercise. He stated that exercise is a necessary component about which the patient and the doctor should have dialogue. He reviewed Su's records of Patient A, and, due to the fact that she did lose weight, Dr. Blackburn concluded that Su must have provided diet and exercise counselling even though it was not documented in the patient record.

Dr. Su did not cause Patient A's diabetes, Dr. Blackburn testified. Dr. Blackburn also stated that Patient A was not seriously obese, and in those cases, pharmaceuticals are not usually utilized until diet and exercise have been tried first without success. He also noted a cautionary commentary which has been issued by the American Medical Association to the effect that anorectics should not be relied upon as a solution to weight control. They are addictive and do nothing to change a person's lifestyle.

Both the State and the Defendant presented oral closing arguments and rested.

Based upon the testimony and evidence presented, the Board made the following Findings and Conclusions:

- 1) That although Patient A's husband was already a patient of Su, Patient A responded to Su's newspaper advertisement which solicited patients for a weight loss program. The patient treated from January through November, 1989.
- 2) From inception of her treatment, Su treated the patient with pharmaceuticals, to wit: Melfiat (an appetite suppressant); hydrochlorothiazide (HCTZ) (a diuretic) and vitamin B-12 at various times throughout her period of treatment. Most notable, Melfiat was prescribed from January, 1989 through October, 1989.
- 3) In February 1989 the patient complained of itchiness and sores on her scalp. Su attributed that condition to ticks on the family pets. He prescribed a treatment shampoo. When the condition persisted, Su's notes indicate that he prescribed hydrocortisone cream, but the Board believed the patient when she testified that Su did not examine her scalp again and that she never got a prescription for the cream. The patient was continued on Melfiat and HTCZ.
- 4) The Board determined that Su conducted at least three (3) blood tests on the patient, but did not discuss the results of same with her.
- 5) The Board believed the testimony of Patient A and her husband to the effect that from February, 1989 through October, 1989 she made numerous complaints to Su about frequent urination and excessive thirst. Su attributed these conditions to the prescribed diuretic and did nothing further to evaluate the symptoms. The patient was continued on the pharmaceuticals. Thirst and urination are noted nowhere in Su's record for the patient.
- 6) The Board finds that as a result of her own efforts, the patient was admitted to the hospital on November 18, 1989, still complaining of excessive thirst and frequent urination as well as tiredness. She was diagnosed by hospital physicians as having diabetes Mellitus.
- 7) The Board accepted Dr. Kahn's testimony as to the fact that a supervised weight control program must include diet, exercise and counseling with the patient, and that pharmaceuticals should be used only as an adjunct. While Dr. Blackburn assumed that the patient was given a diet and exercise regimen, the patient testified that she was not given this program. Further, Su's patient record does not indicate that any diet, exercise or other counseling was given to the patient.
- 8) Based upon the testimony before the Board, the Board finds that Melfiat was prescribed excessively. It is the uncontroverted evidence on the record that Melfiat, if utilized at all, should be limited to a few weeks. Likewise, use of HCTZ and vitamin B-12 is

not medically justified as primary modes of reducing weight. use of drug therapy without diet, exercise and counseling is medically unjustified and does not comport with standards of medical care for a weight loss program.

- The Board also finds that the patient's complaints of excessive thirst, frequent urination and tiredness were largely ignored by Su, and that Su failed to recognize at an early stage of treatment that the patient's symptoms suggested evaluation for Diabetes Mellitus. Su never even ordered a urine test for the patient.
- 10) The Board finds that based upon the testimony and evidence, Dr. Su is guilty of unprofessional conduct in violation of Section 5-37-5.1 of the General Laws.

Based upon its findings and conclusions, the Board hereby

### ORDERS

- 1) That Wu-Hsiung Su, M.D. be, and hereby is, suspended form the practice of medicine until such time as he can establish to the satisfaction of the Board that he has:
- a) satisfactorily completed an educational course in metabolic and endocrine diseases that affect adults;
- b) satisfactorily completed a course in medical records, including documentation of patient histories, symptoms and/or complaints and treatments undertaken.
- c) satisfactorily completed a course in the management of obesity.
- 2) All of the remedial courses described above must have prior approval of the Board of Medical Licensure and Discipline.
- 3) That Wu-Hsiung Su, M.D. be assessed an Administrative Fee of Five Thousand (\$5,000.00) Dollars payable within 60 Days of the date of this order.

ENTERED as an Order of the Board of Medical Licensure and day of September, 1994.

Barbara A. DeBuono, M.D., M.P.H.

Director of Health

Chairman.

Sally Jane Thibodeau, Ph.D Public Member

### Notice of Right of Appeal

In accordance with Rhode Island General Laws 5-37-7 1956, as amended, (re-enactment 1987), you have the right to appeal this decision to the Superior Court by serving the Director of Health with a complaint filed in the Superior Court within 30 days after the decision of the Director.

### <u>Certification</u>

I hereby certify that on the 30th day of September a copy of this order was sent to the following attorneys at law:

Joseph Miller, Esq. 1345 Warwick Avenue Warwick, RI 02888

J. Renn Clenn, Esq. Olenn & Penza 530 Greenville Avenue Warwick, RI 02886